Montana Board of Medical Examiners
PO Box 200513
(301 South Park Avenue 4th Floor - Delivery)
Helena, MT 59620-0513
PHONE: 406-841-2361 FAX: 406-841-2305
E-MAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

RESIDENTS ARE NOT PERMITTED TO PRACTICE MEDICINE IN MONTANA IN ANY MANNER WITHOUT A LIMITED TEMPORARY CERTIFICATE

PLEASE ALLOW A MINIMUM OF 10 DAYS FOR PROCESSING.

LICENSING REQUIREMENTS:

- Must be a graduate of a medical school approved by the American Osteopathic Association or the Council for Medical Education of the American Medical Association.
- Completion of an approved internship of at least 1 year or, in the opinion of the board, has had experience or training that is at least the equivalent of a 1-year internship
- A current resident in good standing with a program accredited by the accreditation council for graduate medical education or the American Osteopathic association
- Currently in the course of an approved rotation of the person's residency program and is seeing other patients under the supervision of a physician who possesses a current, unrestricted license to practice medicine in this state.

FEES: $100.00 – Application Fee **Make payable to Montana Board of Medical Examiners**
$ 50.00 – Extension Fee

DOCUMENTS: The following documents must be submitted to the Board office in order to complete your license application. Please make 8 ½" x 11" copies of the following and submit with your application.

- **Copy of all Current State Medical Licenses or Certificates**
- **Copy of DEA license**
- **Letter of Verification from an Approved Residency Program**

APPLICATION PROCEDURES:

- The letter of Verification from your Approved Residency Program must state that you are in good standing and that your current rotation is part of the training program.
- Upon receipt of a completed application with all the supporting documentation, the application will be reviewed for compliance with the Board's statutes and rules.
- Your application must include the name and address of the unrestricted licensed physician who will be responsible for your supervision.
- The Board office must be informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES:

- An application may take up to 30 days to process from the time it is received in the Board office.
- The applicant will be notified in writing of any deficient or missing items from the application file.

For information with regard to the processing of this application and other concerns, please contact the Board of Medical Examiners staff at (406) 841-2361 or email us at dlibsdmed@mt.gov

PLEASE BE SURE REVIEW THE MONTANA LAWS AND RULES FOR THE PRACTICE OF MEDICINE ON OUR WEBSITE:
http://www.medicalboard.mt.gov

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Application for Limited Temporary Certificate for Resident as:

☐ **Allopathic** ☐ **Osteopathic**

Allow 10 days from the date the Board receives application to process Limited Temporary Certificate

1. FULL NAME _____
   Last First Middle
2. OTHER NAME(S) KNOWN BY _____
   (MAIDEN, NICKNAMES ETC.)
3. BUSINESS NAME _____
4. BUSINESS ADDRESS _____
   Street or PO Box # City and State Zip
5. HOME ADDRESS _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS: ☐ Business ☐ Home E-MAIL ADDRESS _____
6. TELEPHONE (____) _____ (____) _____ (____) _____
   Business Home Fax
7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____
8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ MALE ☐ FEMALE
   City/State
9. LICENSE NAME _____
   (State your name as it should appear on the license if granted.)
10. Which exam did you take for initial licensure?

    ☐ National Boards ☐ FLEX ☐ USMLE ☐ LMCC ☐ State Exam (indicate which state) ____
11. If you are a foreign medical graduate, have you satisfied the requirements of the Education Council for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No
12. Have you ever previously applied for a license to practice in Montana? If yes, give date, and results. ☐ Yes ☐ No
13. Have you ever been denied licensure or the opportunity to take this profession's licensing examination in any state or country? If yes, attach a detailed explanation. ☐ Yes ☐ No
14. Have you ever withdrawn an application for medical licensure? If yes, please give the state and reasons for withdrawal. ☐ Yes ☐ No

15. List all professional licenses you hold or **ever** have held.

State	License #	Issue Date	Expiration Date	License Method
				☐Exam ☐ Endorse ☐Other
				☐Exam ☐ Endorse ☐Other
				☐Exam ☐ Endorse ☐Other

16. **RESIDENCY/INTERNSHIP**:

Internship Program	City and State/Province/Territory	Dates Attended	Diploma Received
			☐ Yes ☐No
			☐ Yes ☐No

Residency Program	City and State/Province/Territory	Dates Attended	Diploma Received
			☐ Yes ☐No
			☐ Yes ☐No

17. **MONTANA SUPERVISING PHYSICIAN**

Please type or print names and addresses of supervising physician (must be MD or DO), who are actively licensed unrestricted in Montana.

Physician Name: Physician MT License #:
Physician Address:
Physician Telephone Number:

Physician Name: Physician MT License #:
Physician Address:
Physician Telephone Number:

15. DATES OF RURAL ROTATION: _____
From/To

16. NAME OF APPROVED RESIDENCY PROGRAM: _____

ADDRESS: _____
Street/PO Box City State Zip

PHONE: _____

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____
Legal Signature of Applicant Dated

Subscribed and sworn to before me this _____ day of _____, _____
at _____.
City/State

_____
Signature of Notary Public

SEAL

_____
Printed Name of Notary Public

_____
For the State of

My commission expires _____.